



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
WOLMED

Respondent Name
NATIONAL INTERSTATE INSURANCE

MFDR Tracking Number
M4-07-0326-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
OCTOBER 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier in this case preauthorized the WOLMED chronic pain management program and then refused to pay for the program...The adjuster in this case filed a PLN-11."

Amount in Dispute: \$ 19,832.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The request for Medical Dispute Resolution is not timely...As reflected on explanations of the benefits, the primary basis for the denial of reimbursement in this case is that the services performed were not to treat the compensable injury."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 1, 2015 through October 8, 2015	Chronic Pain Management Program CPT Code 97799-CP-CA	\$19,832.00	\$0.00

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 219-Based on extent of injury.
- 190-Based on extent of injury, not finally adjudicated.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- 350-Bill has been identified as a request for reconsideration or appeal.

Issues

1. Does the medical fee dispute referenced above contain unresolved issues of Extent-of-Injury? Is the dispute eligible for review?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. The requestor seeks resolution for a chronic pain management program rendered to claimant from September 1, 2015 through October 8, 2015. A review of the submitted explanation of benefits finds the following:
 - The respondent partially paid for the program on September 1 and 2, 2015 based upon "P12-Workers' compensation jurisdictional fee schedule adjustment."
 - No payment was made for the program on October 6, 2015, based upon reason code "P12."
 - All other dates of service were denied payment based upon "190-Extent of Injury. Not finally adjudicated" and "219-Based on extent of injury."

Review of the submitted documentation finds that the medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute. The Division finds that the dispute contains unresolved issues of Extent-of-Injury. As a result, the dispute is not eligible for review by MFDR until final adjudication of the Extent-of-Injury issues.

The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of Extent-of-Injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the Extent-of-Injury dispute.

2. As stated above, only services rendered on September 1, September 2, and October 6, 2015 do not involve issues regarding extent of injury. The respondent states in position summary that "The request for Medical Dispute Resolution is not timely."

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not

timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 7, 2015. Review of the submitted documentation finds only services rendered on September 1, September 2, and October 6, 2015 do not involve issues regarding extent of injury. The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

HOW TO FILE FOR RESOLUTION OF COMPENSABILITY, EXTENT-OF-INJURY AND/OR LIABILITY

A health care provider that chooses to pursue resolution of the Compensability, Extent-of-Injury and/or Liability issue(s) should submit the following **to the field office handling the injured workers claim:**

➤ Completed DWC Form-045 *Request to Schedule a BRC*, including:

- Section III. PARTY REQUESTING

- ✓ 10. Select Sub-claimant

- Section IV. ISSUE(S) TO BE MEDIATED

- ✓ 17. Select "Extent-of-injury"

- ✓ 18. State the following: **"Do any or all of the services provided in the attached medical bill(s) extend to the compensable injury of the injured employee?"**

THIS
QUESTION
MUST BE
ANSWERED AT
THE BRC

➤ Attach to the DWC- Form045:

- ✓ a copy of the dismissal and this page;

- ✓ medical bills for date(s) of service:

- ✓ **notify the injured employee as required by 28 Texas Administrative Code §140.6 (c)(2)(D), Subclaimant Status; and**

- ✓ any other information/documentation required in the form instructions.

Health Care Provider Frequently Asked Questions (FAQ) and Answers

Question: Whom can I call with questions about the dismissal?

Answer: You may contact the dispute resolution officer that issued the notice or MFDR via email at MDRInquiry@tdi.texas.gov. Please include the MFDR tracking number in your email.

Question: Why was my dispute dismissed?

Answer: The dispute contained unresolved issues of Compensability, Extent-of-Injury and/or Liability. The Compensability, Extent-of-Injury and/or Liability issue(s) for the date(s) of service in dispute must be resolved prior to determining the fees reimbursement amount(s). MFDR cannot take action on the service date(s) at this time; for that reason, the medical fee dispute was dismissed.

Question: What are my options?

Answer: The healthcare provider has the option to pursue resolution of the, Extent-of-Injury, Compensability and/or Liability issue as instructed above; or provide documents to support that a final decision on, Extent-of-Injury, Compensability and/or Liability was made for the date(s) of service in dispute.

Question: How can I get a copy of a DWC Form-045?

Answer: Go to www.tdi.texas.gov/wc/forms or call CompConnection at 1-800-372-7713 option 3 if you require a copy by fax or mail.

Question: Whom can I call with questions about completing and filing the DWC Form-045 Request to Schedule a BRC?

Answer: Contact your local field office - <http://www.tdi.texas.gov/wc/dwcccontacts.html>

Question: Can I submit a new dispute or DWC Form-060 after resolution of the, Extent-of-Injury, Compensability and/or Liability issue?

Answer: Yes. The medical fee dispute may be submitted for review as a new dispute. The provider should include any new EOBs, and the final decision on, Extent-of-Injury, Compensability and/or Liability for **date(s) of service in dispute.**

Question: Will my new medical fee dispute or DWC Form-060 be denied if it is filed later than one year?

Answer: If the healthcare provider submits documents to support that a final decision on, Extent-of-Injury, Compensability and/or Liability was made for the **date(s) of service in dispute,** the one-year filing deadline does not apply. The provider is responsible for filing the dispute no later than 60-days after it receives a final decision on, Extent-of-Injury, Compensability and/or Liability for the date(s) of service in dispute.